

Clinical Decision Making – Test 3

• Clinical Decision Making

○ Health Law

▪ Objectives

- Define medical malpractice and describe the required elements of a successful medical negligence claim
- Explain terms and concepts common to malpractice litigation and tort reform
- Illustrate techniques to minimize professional liability (risk management)
- Describe national medical liability reform legislation and discuss its potential impact on the malpractice crisis

▪ General surgeons are avoiding things that could get them sued

▪ Malpractice – unwarranted departure from accepted medical practice resulting in injury to a patient

- Most frequently sued – OB/GYN, internists, general surgeons, ortho, radio, family
- 4 Elements that must be proven for there to be malpractice
 - **Duty** – “standard of care”, what a *reasonable* physician would have done (or not done) under the same or similar circumstances
 - It is a *national* standard of care that *constantly changes*
 - Must be defined by an ‘expert’ that must be
 - Licensed to practice medicine
 - 75% of time in active practice or its instruction
 - Practices same/similar specialty
 - Has training in health care matter at issue
 - **Breach** – there must be negligence?
 - **Commission** (misfeasance) – improper performance of an act (giving wrong medicine)
 - **Omission** (nonfeasance) – failure to act (ex. failing to follow up on abnormal test results)
 - **Cause** – actions must have ‘more likely than not’ caused the problems (50% rule) (very loose standard)
 - **Harm** – must result in harm (injury, death, etc)
 - Thus it is possible to be negligent, but not have malpractice
- National Practitioner Data Bank – all malpractice cases are reported here and it is *public*
 - Can adversely affect licensing, clinical privileges, professional society membership
 - Can affect medical malpractice payments
 - Medicare/Medicaid exclusion reports?

▪ Terminology

- **Tort** – a *civil* wrong committed against a person (or property) for which there are damages
 - If convicted results in payment of monetary damages for injuries
 - Not crime, no jail
 - **Unintentional Tort** – negligence
 - **Intentional Tort** – battery (unwanted touching or unwanted care), invasion of privacy
 - **Statutory Tort** – product liability (some medical device you sell goes bad)
- **Compensatory Damages** – attempts to *make person whole* for injuries suffered
 - **Economic Damages** – ex. medical expenses, lost wages, future earnings, etc. *objective*
 - **Non-economic Damages** – *subjective*, ex. pain and suffering, emotional distress, loss of consortium (wife losing sexual function of husband)
- **Punitive Damages** - *punish the defendant* and deter future similar conduct
 - Seen moreso in *intentional torts*
- **Statute of Limitations** – in Ohio it is generally 1 year from the time the cause of the action accrues (ie, when negligence *occurs* or *discovery* of the negligence as long as *reasonable diligence* in discovering claim
- **Contingency Fee Contract** – attorney fee as % of recovery; often 33-40%

▪ Minimizing Liability

- Why patients seek lawyer to file a claim
 - Physician attitudes 35%
 - Physician Communication 35%
 - Patient’s financial incentive 10%
 - Media Attention 7.5%, Physician disparagement 7.5%, unrealistic patient expectations 5%

- What to do
 - Limit practice to scope of training, be explicit about all instructions given to patients, obtain proper consent, select/supervise appropriate staff, check condition of equipment, document all information in patient's record, involve patients in decision-making, continue medical education, assure continuity of care (note that there is a specific procedure to remove someone from your practice)
 - Best thing to do is maintain good rapport with your patients
 - Malpractice suits often result when an unexpected adverse outcome is met with a lack of empathy from physicians withholding of essential information
 - 4 C's
 - **Competence** – limit practice to areas in which you are proficient, secure adequate coverage when away
 - **Charting** – never alter records, if you didn't record it it didn't happen
 - **Communication** – fully inform/educate patients about all aspects of their medical condition (consent)
 - Maintain communication with patients/families through difficult periods
 - **Compassion** – do it
 - The Good News
 - 74% - closed without payment to patient/plaintiff
 - 20% - pretrial settlement (through negotiations)
 - 6% result in jury trial (physician won 91% of those)
 - overall, patient wins only 20% of the time
 - Legislative Activity
 - Tort Reform – hotly debated, need caps on *non-economic damages*, punitive damages, contingency fees
 - Physician population doubled in states that had caps on non-economic damages
 - Rural physicians, surgeons, and ob/gyns were most likely to be affected by caps
 - MCAP Act
 - Purpose – improve availability of health care services, reduce incidence of defensive medicine, lower cost of health care liability insurance, ensure patients with meritorious health care injury claims receive fair compensation
 - 4 Areas
 - Encourages Speedy Resolution of Claims
 - Lawsuit must be filed no later than 3 years after the date of injury or 1 year after patient discovers injury
 - Extends time for minors injured before age 6
 - Compensates patient injury
 - No limit to economic damages, but limit non-economic damages to 250,000
 - Limit punitive damages to *greater* of 2x economic damages or 250,000
 - Must prove malicious intent
 - Compensatory damages must be awarded first
 - **Fair Share Rule** – if multiple parties, then each party only liable for their share
 - Payments can be paid on a payment plan
 - Maximize Patient Recovery
 - Limits attorney contingency fees to a sliding scale
 - Expert witnesses must be licensed and experienced with standard of care in case
 - Prevents Duplication
 - Courts reduce damages by the amount of any other source of benefits to which the patient is entitled (ie health insurance)
- **Health Economics**
 - Objectives
 - Describe attributes of organizations that manage health care (HMO, PPO)
 - Discuss features of various reimbursement methodologies (fee-for-service, capitation)
 - Describe characteristics of key health care payers (medicare, etc)
 - Explain terms and concepts common to discussions regarding physician payment
 - \$200 charge, on average insurance allows \$83.83, but only pays 80% of that (the rest if for copay)
 - Organizations

- **Health Maintenance Organization** – provides comprehensive health care, has physician gatekeepers (primary care physicians), has limited referrals to outside specialists/hospitals, may have lower out-of-pocket costs, may cover more services (ie health/wellness programs)
- **Preferred Provider Organization (PPO)** – economic incentives (lower copays etc) to utilize certain physicians and hospitals (the preferred providers)
 - Don't need a primary care physician referral
- **Reimbursement Methodologies**
 - **Fee-For-Service** – physician paid for each service provided (per episode of care)
 - **Capitation** – per member per month amount prepaid to physician (fixed amount, fixed time schedule)
 - Based on gender and age
 - Conflict of interest for each reimbursement method
- **Payers**
 - Who – 41% use commercial insurance, 35% use medicare, 18% Medicaid, 4% self pay
 - **Medicare**
 - Who's Covered – ≥ 65 , or <65 with certain disabilities, or all ages with end stage renal disease
 - Covers without regard to income or medical history
 - Covered Services
 - **Part A** – hospital insurance (inpatient, nursing facility, hospice, home health care)
 - Entitled to this if you contributed payroll taxes for at least 10 years
 - Funded by dedicated tax of 2.9% of earnings
 - **Part B** – medical insurance (physician services, outpatient, preventative services, home health)
 - Funded by beneficiary premiums deducted from SS checks and general revenues
 - Now has income related premium for individuals over a certain income
 - Does cover preventative services – one time “welcome to medicare” physical exam, glaucoma test, cancer screening etc.
 - **Part C** – medicare advantage plans (a privately managed care plan)
 - **Part D** – prescription drug coverage (run by private companies approved by medicare)
 - What patient pays – monthly premium, \$295 deductible for prescriptions
 - Copayment or coinsurance until \$2700
 - Coverage Gap - \$2700-4350
 - Catastrophic coverage – small copayment for each drug until end of year
 - Physician Payment
 - **Allowed** – maximum amount allowed to be collected for medical services from all sources of payment (the medicare approved amount)
 - **Deductible** – amount patient must pay before insurance begins to pay
 - **Coinsurance** – amount patient is required to pay for services after paying any deductible (often a %)
 - **Copayment** – amount patient pays for each medical service (often a set amount)
 - **Medigap** – costs patient must pay?? This would have to be covered by other insurance?
 - Viability
 - There will be almost twice as many patients in 2030 and 1/3 less worker to pay for them
- **Medicaid**
 - Who's Covered – *state and federal* health program
 - *State administered* (each state operates its own program within federal guidelines)
 - Those who meet eligibility requirements are guaranteed coverage through Medicaid
 - Children (up to age 19), pregnant women, families with children younger than 19, adults age 65 and older, legally blind, disabilities, certain women screened for breast and cervical cancer
 - Must be – US citizen, ohio resident, have social security number, meet income requirements
 - Income – less than 30,000 for children; less than 13 for a family with children
 - Covered Services –
 - Federally mandated services – transportation, home health, nursing facility, family planning services, medicare premium assistance, physician services
 - Ohio optional services – ambulance, dental, prescription drugs, addiction treatment, etc.
 - **Healthy Start** – coverage to children (<19) and pregnant women
 - **Healthy Families** – option for entire family to access coverage

- **Healthcheck** – Ohio’s early and periodic screening, diagnosis and treatment program (<21)
 - Helps those eligible pay costs of medicare which they can’t
- Physician Payment
 - ↓ overall costs by 3-5% when compared to FFS system
 - must assure access to a designated primary care provider, emphasize preventative care and encourage appropriate utilization of services in most cost-effective setting?
- Commercial Insurers
 - Private insurance contracts, employer subsidized, patient purchased
- **Documentation**
 - **Objectives**
 - Describe and recognize characteristics of “good” patient documentation
 - Discuss and apply techniques to minimize liability (risk management) when documenting a patient encounter
 - Explain and identify components of a SOAP note
 - Document a patient’s chief complaint and history of present illness
 - Users of your documentation – numerous
 - Uses
 - Coordinate Care – communicate essential information to healthcare team, including payers
 - Assess quality of care – quality improvement committee, payers etc.
 - Minimize risk – via documentation, preven malpractice
 - Train Students –
 - Conduct research
 - Inadequate records → medical errors, ↓ quality of care, insurance denial, ↓ damages in MV lawsuits
 - “every medical malpractice suit can be won or lost based on the quality and content of the medical records”
 - Family physicians lose about 20% of reimbursement because they don’t properly code or document
 - Good Documentation
 - Comprehensive, complete, clear, concise, discrete, respectful, timely, legible, accurate, organized
 - Note – courts have allowed inference of negligence where medical records fail to include certain data
 - Ex. “doin OK” isn’t enough, must say “less pain today, ate full diet, fully ambulatory”
 - Risk Management
 - Approved Abbreviations – only use these
 - Penalty for Altering/Falsifying Records – jeopardize malpractice defense, liability insurer could cancel coverage, criminal charges for fraud or perjury, medical liscense revocation
 - They can use forensics to see if you altered the record
 - Errors
 - Erasures arouse suspicions in the minds of jurors, so correct errors properly
 - How to correct an error
 - Single strike-through line
 - Initialed
 - Dated/timed
 - Identified as ‘error’
 - How to update patient record
 - Date annotation truthfully (don’t backdate)
 - Specify that you’re adding it after the fact
 - State why the information was omitted
 - SOAP Note
 - **Subjective** – information *from patient or family*
 - Includes CC, HPI, Fam/Soc History, Review of Symptoms
 - **Objective** – information *from your observations*
 - Physical exam, vital signs, lab results
 - **Note** – be able to differentiate between the two from examples
 - **Assessment** – describe your impression of the current medical problems including differential diagnosis and/or your reasoning behind your medical impressions
 - **Plan** – plan for treatment and follow-up

- May include medications or additional diagnostic studies and therapies

○ **Health Disparities & Community Health Assessment**

▪ **Health Disparities Objectives**

- Define and describe health and health care disparities
- Provide information on six major disparity areas affecting the US
- Describe selected factors that contribute to disparities
- Discuss ways to combat disparities

▪ **Community Health Assessment Objectives**

- Describe the benefits of a community health assessment
- List typical committee members involved in a community assessment
- Describe topic areas to be assessed
- Evaluate next steps after an assessment

▪ **Health Disparities**

- **Health Disparities** – differences in incidence, prevalence, mortality and burden of *disease* and other adverse health conditions that exist among specific population groups
- **Healthcare Disparities** – any differences in *access to health care* and quality of health care among populations
- Health disparities and healthcare disparities feed off one another
- Note – life expectancy of college graduates is 5 years longer than those who do not finish high school
- 6 Major Disparity Areas
 - **Infant Mortality** – US has terrible infant mortality rate compared to rest of the world
 - Af. Am. Have 2x ↑ infant mortality than white
 - Af. Am also more likely to have low-birth weight babies, premature births, not seek prenatal care
 - Example of a healthcare disparity leading to a health disparity
 - **Cancer Screening and Management** –
 - Cancer death rates are higher in men than in women
 - Hispanics have higher rates of cervical, esophageal, gallbladder and stomach cancer
 - Asian Americans have higher rates of stomach cancer
 - Disproportionate Mortality rates – af am women (breast and colon cancer), af am men (lung, prostate, colorectal)
 - Late detection is often the culprit (less screening)
 - **Cardiovascular Disease and Stroke** –
 - CVD Mortality rate ↑ in men
 - 42% ↑ in af am men, 65% ↑ in af am women
 - Stroke accounts for more deaths in *women* than men
 - **Diabetes**
 - Incidence – natives diagnosed 2.6x more, af am diagnosed 2x more
 - End stage renal disease – af am have 4x greater rate
 - Lower extremity amputations – af am have 2x greater rate
 - May be more troublesome for women?
 - **HIV/AIDS**
 - Minorities account for 66% of the AIDS population and 82% of the pediatric AIDS pop
 - Affects women disproportionately in US
 - **Child and Adult Immunizations**
 - Lower levels of immunizations in minorities (controlling for SES)
 - Lack of education and concern about adverse effects may contribute
- What Factors Cause Disparities
 - **Lack of Health Care Coverage** - Young adults and minorities are least likely to be insured
 - **Socioeconomic Status** – rates of illness in low SES adults in 30s-40s are comparable to affluent adults in their 60s and 70s
 - Income, education and occupation are highly correlated with race
 - **Literacy**
 - **Single greatest predictor of an individual's health status**
 - **Almost half of all American adults have problems with literacy - Murtha 2004**

- **Health care costs for patients with low literacy are estimated to be 4 times higher than for those with higher levels of literacy – Murtha 2004 ‘toward culturally competent care: a toolbox for teaching communication strategies**
 - People often read 3 grades lower than their last year of education
 - Minorities, immigrants and elderly are disproportionately affected
- **Medical Care**
 - Health care provider bias may be a problem
 - Minorities more likely to distrust the medical system
 - Under representation of minorities in health careers
- **Patient-Related Factors**
 - Adherence rates for healthy living guidelines may vary by race
 - Non-english speaking
- What is being done
 - Focus on population-based care
 - Educate yourself on the disparities that exist
 - Promote health literacy
 - Promote the adoption of healthy lifestyles
- **Community Health Assessment**
 - Benefits
 - Provides basis for rational planning, actions and evaluations
 - Promotes collaborative actions
 - Avoids duplication of efforts
 - Guides appropriate use of scarce resources
 - Promotes community-wide concerns about appropriate care
 - Committee Members – hospitals, health departments, public agencies, county commissioners, united way, local community foundations, family councils, churches, nonprofit organizations
 - Things Assessed
 - Adults
 - Survey goes out by local mail with free cash, questions taken from CDC Behavioral Risk Factor Surveillance System
 - Topics – health perceptions, coverage, access, cancer, tobacco, preventative, etc.
 - Youth
 - Survey performed in classroom, passive permission slips handed out, report by county
 - Topics – tobacco, alcohol, drugs, violence, safety, sexual health, weight control, oral health, mental
 - Next Steps
 - Focus groups, key informant interviews, choose priorities, secure funding, evidence based programming, boost marketing for unknown programs that already exist, evaluation plan
 - Some NW Ohio stats – diabetes 2x ↑ in af am, BMI ↑ , 50% have guns, 1/3 of youth overweight
- **Public Health and You & Public Health Surveillance**
 - **Public Health and You Objectives**
 - Identify public health achievements
 - Distinguish public health from traditional medical management
 - Describe aspects of public health
 - **Public Health Surveillance Objectives**
 - Name and describe the three core public health functions
 - Describe the purposes of public health surveillance
 - Identify sources of data used in PH surveillance
 - **Public Health and You**
 - Public health tracks down the causes of disease outbreaks and stops them
 - **Public Health Definitions**
 - Activities that society does collectively to assure the conditions in which people can be healthy. This includes organized community efforts to prevent, identify, preempt and counter threats to the public’s health

- The level of well-being of the general population; those actions in a community necessary to preserve, protect, and promote the health of the people for which government is responsible; and the governmental system developed to guarantee the preservation of the health of the people
- Public Health vs. Medical Management
 - Public health - focus on health status of populations; public service ethic tempered by concerns for the individual; emphasis on prevention and health promotion; activated all of the time
 - Medical Management – focus on clinical improvement of individual patients; personal service ethic conditioned by awareness; emphasis on diagnosis and cure; activated when a person is injured or ill
- Five Aspects of Public Health
 - **Protecting People From Disease** – communicable disease, immunizations
 - **Assuring for Healthy Environment** – drinking water, waste, vectors, food, chemicals
 - **Prevention and Health Promotion** – chronic disease prevention; family health issues
 - **Access to Health Services** – family planning; oral health etc
 - **Understanding Health Issues** – epidemiology, bioterrorism, child death review
- Overview of Public Health Surveillance
 - Core Functions of Public Health
 - **Assessment** – monitor health of pops to identify health problems and priorities
 - **Policy Development** – make sure policies solve pop health problems
 - **Assurance** – assure that all populations have access to effective care
 - Process of Public Health Surveillance – what is the problem? → what is the cause? → what intervention works? → how do you implement that intervention?
 - Purposes of Public Health Surveillance
 - Assess public health status
 - Define Public health priorities
 - Evaluate programs
 - Stimulate research
 - Ex – portray natural history of a disease, evaluate control measures, monitor changes in infectious patients, facilitate planning, estimate magnitude of the problem
 - Ex – determine causal pathway of disease or disability
 - Sources of Data used in Public Health Surveillance
 - Environmental monitoring systems, vectors, labs, medical records, administrative records, police records
 - Notifiable diseases, lab specimens, vital records (births and deaths), registries, surveys, etc.
 - **National Notifiable Diseases Surveillance System** – report certain diseases to national level
 - Reporting mandated at *state* level; reportable diseases vary by *state* level
 - Providers report to county, county reports to state, state reports to agency
 - **Passive Surveillance** – provider initiated (ex national hospital discharge survey?)
 - **Active Surveillance** – health department initiated (ex national health interview survey?)
 - **Sentinel Surveillance** – use one case as tip of iceberg
- **Medical Student Honor Code**
 - **Objectives**
 - Gain and understanding of the Honor Code System and Procedures
 - Apply the Honor Code vignettes
 - Describe the role of UTCOM Honor Code Committee in fostering medical student professionalism
 - Student run, student driven, 15 member committee
 - Establish minimum standards of honor to which every medical student and physician should subscribe
 - **The Code** – acknowledging that a physician is expected to adhere to the highest standards of *honesty, integrity and professionalism*, I will strive to uphold these virtues and will neither cheat, deceive or exploit others, nor tolerate those who do
 - Goal is to educate, not discipline
 - **The Goal** – change the culture of the college of medicine and create an environment where all students appreciate, understand and are willing to participate in honor education and implement it throughout their entire career
 - Mimics the state medical board and professional societies
 - Trust is essential to the practice of medicine and to preserve the autonomy of the medical profession

- Process
 - Student witnessing problem must approach the perpetrator to clarify before things before reporting it
 - This provides opportunity for self reporting etc.
 - Then tell someone on the honor code committee
 - Fact finding mission
 - Then have honor code hearing
 - If guilty, then person goes to remediation
- Consequences
 - Meet with faculty mentor on regular basis (Dr. Marco)
 - Make journal entries
 - Case for use in future honor education?
 - Summary essay of mentorship experience

• Ethics

◦ Minors and Healthcare

- **Objectives**
 - Demonstrate understanding of mature minor doctrine, emancipated minor doctrine, specific issues in minor's healthcare
- Evidence suggests that for more sensitive issues, teens will often defer care if parents are informed (15% vs 65%)
- **Informed Consent** – requires that before a medical procedure is performed the patient must agree and that the following must be explained: 1. why the procedure is necessary, 2. nature and purpose of procedure, 3. risks and benefits, 4. alternatives, including no treatment
- **Mature Minor** – a minor that is *judged by a physician* as being capable of given informed consent and understanding ramifications of treatment
 - Varies by state (always over 12 years old)
 - No paperwork needed
- **Emancipated Minor** – means that person has *legal adulthood*, generally a teen that is self-supporting (married, military, incarcerated, living apart from parents)
 - Specifics vary by state, in Ohio minors *can't be emancipated* but may be inherently emancipated
- Mature vs. Emancipated
 - Emancipated minors can consent to *all* of their own health care
 - Mature minors can consent to *some* (and is much more common)
- Protected Health Information
 - Disclosure of Protected Health Information
 - Unless otherwise specified, a medical provider may not reveal confidential information about a patient without the permission of the person who consented to the health care
 - Thus, if a minor consents by themselves, then info can't be released to parents
 - Insurance may still list items
 - If parent consents for child then they can get info
 - Release of PHI
 - If using parents insurance, PHI may be released due to use of insurance
 - Teen can instead pay personally, or find a free place
 - When can PHI be released without any consent
 - Mandated government reports; duty to warn third parties; for court; suspected abuse
- Specific Issues in Adolescent Healthcare
 - Emergency Care – treatment can be rendered if the delay needed to get consent would threaten a child's life or cause a negative impact on health
 - PHI can be released to parent if, once child is stabilized, the initial condition would be one in which consent would be normally required
 - STIs – minors can be diagnosed and treated for STIs without parent's consent (but parents don't have to pay if they didn't give consent)
 - PHI can't be released except for surveillance reports and to warn third parties
 - Family Planning/Birth Control – government cannot restrict access to birth control/abortion
 - Adolescents can consent to birth control and gynecologic care

- Physician can give birth control if judged mature
- Adolescent *must get parent permission* to have abortion in Ohio (unless married and over 17)
 - Can seek **Judicial Bypass**
- Teen cannot be forced to have abortion
- In Ohio, must have 2 *doctor's visits* at least 24 hours apart before getting abortion
- Mother does not have to tell father of decision to have abortion
- Mental Health Services
 - Adolescent can have *outpatient* therapy *without parental consent* for 30 days or 6 sessions if >14
 - After that parents must consent, parents must also consent to any medications
- Substance Abuse - >12 can consent to alcohol and drug treatment without parental consent
- All teens should have private time with physician
- **Stewardship of Healthcare Resources**
 - **Objectives**
 - Describe the principle of justice as applied to stewardship of health care resources
 - Identify ramifications of the high rates of uninsured patients in the US
 - Compare proposed solutions to the high rates of uninsured patients, and their advantages and disadvantages
 - Discuss ethical dilemmas related to stewardship of health care resources
 - Formulate a coherent approach to the appropriate stewardship of health care resources
 - **Cost Containment in Health Care**
 - Cost-Sharing via deductibles and co-pays
 - Explicit rationing – only certain services covered, gatekeepers
 - Capitation – limits on expenditures; spending priorities
 - **AMA Principles of Medical Ethics**
 - A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights
 - A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities
 - A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health
 - A physician shall support access to medical care for all people
 - **Principles of Ethics**
 - **Autonomy** – patient's right to determine health care
 - **Beneficence** – doing good for the patient
 - **Nonmaleficence** – not doing harm
 - **Justice** – considering actions in the larger community setting of stewardship of resources
 - Why crisis in ER – more uninsured patients, less access to outpatient care, more elderly, fewer inpatient beds, fewer on-call consultants, shortages of health care providers
 - 83% of the uninsured are working families not eligible for Medicare or Medicaid
 - 21% of Af Am not insured, 34% of Hispanics not insured
 - Solutions to uninsured problem – universal health coverage, tax credits to employers and individuals, insurance vouchers, increased Medicaid funding, increased federal reimbursement to safety-net institutions
 - Principles for reform of the US health care system 2007 laid out principles for reform of US health care
 - **Physician's Role**
 - Take care of each individual patient
 - Advocate for legislation to increase funding for social programs
 - Participate in organizations that promote allocation of health care resources
 - Participate in tort reform
 - Participate in health care reform
- **End of Life**
 - **Objectives**
 - What are the legal and ethical guidelines with regard to withholding and withdrawing treatment?
 - What is advance care planning and how should clinicians see themselves in this process?
 - What are Ohio's advance directives and how do they help clinicians and patients?

- Withdrawing and withholding treatment are *equally justifiable* ethically *and* legally. Treatments should not be withheld because of the mistaken fear that if they are started they cannot be withdrawn
- **Life-Sustaining Treatment** – any treatment that serves to prolong life without reversing the underlying medical condition
 - Artificial administration of nutrition and fluids is a life-prolonging treatment and should be viewed no differently than a ventilator.
- The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the preference of the patient should prevail. The principle of patient autonomy requires that the physicians respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity
- There is a difference between refusing/withdrawing life-sustaining treatment and physician assisted suicide and you need to make sure the patient knows that
- Competent patients are permitted to refuse virtually any treatments, even highly beneficial ones with few side-effects
 - Even if their family, friends or physicians disagree with them
- Questions to ask – are there treatments you particularly want to refuse? Why?, what are you afraid might happen if you can't make decisions yourself?, do you have any particular fears or concerns about the medical treatments that you might receive?
- Make sure the physician understands the patient's values and wishes and make sure the physician will carry them out
- Ohio Directives
 - **Terminal Illness** – an irreversible, incurable and untreatable condition caused by disease, illness or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by the attending physician and one other physician who has examined the patient, *both* of the following apply:
 - There can be no recovery
 - Death is likely to occur within a relatively short period of time if life-sustaining treatment is not provided
 - **Permanent Unconscious State (PAS)** – see jargon above and must have *both* of the following
 - Patient is irreversibly unaware of self and environment
 - There is a total loss of cerebral cortical functioning, resulting in the patient's having no capacity to experience pain and suffering
 - **Durable Power of Attorney for Health Care** – goes into effect for purposes of removal or withholding life sustaining treatment when a patient has *irreversibly* lost decision making capacity and is *terminally ill or in a PUS*
 - Limits
 - one must act consistently with the desires of the person or, if unknown, in the best interest of the person
 - Can withhold previously consented to therapy if: condition changed significantly or that care is no longer effective
 - Grounds for Appeal
 - Patient has not lost decision making capacity currently or permanently
 - Decision is inconsistent with family or previously expressed interest
 - Document expired; document filled out under duress
 - **Living Will** – goes into effect when the patient has when a patient has *irreversibly* lost decision making capacity and is *terminally ill or in a PUS*
 - For purposes of out of state documents, witnessing or notarization, where to keep documents,
- **End of Life 2**
 - **Objectives**
 - **End of Life Care** – care for persons who have reached a time in the trajectory of their disease when the focus no longer is driven by attempts to control the disease
 - Care is focused on management of symptoms and quality of life for patient and family
 - In 2nd half of century US medicine intensely focused on always trying to fix problem and never letting one die
 - Death denying, value for productivity youth and independence, devalue age, age of entitlement (to care)

- <10% die suddenly, 90% die after predictable decline or slow decline punctuated by periodic crises (ex CHF)
- 90% want to die at home, but 70% don't (and it had been on the rise)
- **Palliative Care** – relieving symptoms, not curing disease
- A lot of people die in pain even though meds could control that
- Attention to symptoms in a holistic fashion has not been set as a priority
- **Hospice** – a mode of palliative care that deals entirely with end of life
 - Usually precludes curative therapy
- How to identify who will benefit from end of life care – ask “which of your patients is sick enough that death within a few months would not be surprising?”
- End of life care may be indicated after exacerbation of chronic disease treated in ICU with no improvement
 - Or severe compromise in brain function from injury
- Beneficence – this isn't always obvious
- Respect for Persons (end of life) – must maintain informed consent; patient still gets role in decision making
- Justice – provide all persons with equal treatment opportunities
- Discussions with Family
 - Discuss prognosis and achievable goals
 - Document advanced directives
 - Etc.
- Special Issues in End of Life Care - Withholding or withdrawing nutrition and hydration; removal of ventilator support; giving bad news; palliative sedation; clinical trials; roll of timing of chemotherapy
- Life-Sustaining or Death Prolonging? – resuscitation, elective intubation, surgery, dialysis, diagnostic tests, artificial nutrition/hydration, etc.
- Barriers to good end of life care
 - Discomfort communicating “bad” news, prognosis
 - Lack of skill negotiating goals of care, setting treatment priorities, discussing futile therapy
 - Personal fears, worries, lack of confidence
- Grief Management
 - If their coping strategies are appropriate then just monitor them and provide support (counseling)
 - If their coping strategies are inappropriate then provide rapid, skilled assessment and intervention